HUMAN SERVICES DEPARTMENT [441]

Adopted and Filed Emergency After Notice

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," and Chapter 81, "Nursing Facilities," Iowa Administrative Code.

These amendments rescind the amendments that were Adopted and Filed Emergency and published in the Iowa Administrative Bulletin on December 2, 2009, as **ARC 8344B**, and readopt them after a notice period to solicit public comments. The amendments reduce the reimbursement for most Medicaid services to achieve the savings required by Executive Order 19, which mandated a 10 percent across-the-board cut in expenditures. Specifically, these amendments:

- Reduce the rental allowance for durable medical equipment from 150 percent of the purchase price to 100 percent of the purchase price.
- Reduce the reimbursement for nonemergency medical transportation by private automobile from 34 cents per mile to 30 cents per mile.
- Reduce the reimbursement for generic and brand-name specialty drugs from the average wholesale price less 12 percent to the average wholesale price less 17 percent.
- Reduce the multiplier used to calculate the state maximum allowable cost for generic drugs (SMAC) from 1.4 to 1.2.

- Reduce the pharmacy dispensing fee from $4.57 to $4.34 from December 2009 to June 2010.

- Reduce payments to the following providers by 5 percent for services rendered from December 2009 to June 2010: hospitals (not including critical access hospitals), nursing facilities, and psychiatric medical institutions for children; physicians, podiatrists, advanced registered nurse practitioners, audiologists, occupational and physical therapists, psychologists, optometrists, opticians, and chiropractors; dealers of medical equipment and supplies, hearing aids, orthopedic shoes, and prosthetic devices; remedial and behavioral health services, laboratory, X-ray, and ambulance providers; ambulatory surgical centers, maternal health centers, clinics, home health agencies, rehabilitation agencies, lead inspection agencies, and screening centers.

- Reduce payments to the following providers by 2.5 percent for services rendered during the period December 2009 to June 2010: dentists, community mental health centers, targeted case management providers, and home- and community-based waiver service providers.

- Provide that computation of administrative, environmental, and property expenses for nursing facilities shall be based on 90 percent of facility capacity, instead of 85 percent, unless the number of inpatient days is higher.

- Provide that nursing facilities shall be reimbursed for holding a bed for a hospitalized resident only if the facility's occupancy rate is at 95 percent or more. For those facilities whose occupancy rate meets that level, the payment will be made at 25 percent of the facility's daily rate, instead of 42 percent of the daily rate.

Notice of Intended Action on to solicit comments on these amendments was published in the Iowa Administrative Bulletin on December 2, 2009, as **ARC 8345B**. The Department

received comments on the Notice of Intended Action from eight people. Areas of concern included the effects of the reimbursement reductions on:

- Case management providers that already receive reimbursement with a retrospective cost-settlement,
- Nursing facilities, especially those with a high percentage or Medicaid residents or low utilization,
- Providers under the home-and community-based intellectual disabilities waiver, whose nonfederal match is paid by county governments, and thus generate no state savings;
- Specialty drugs, specifically Synagis®, which require repeated administration to be effective.

In response to these comments, the Department has made the following changes to the rules as Adopted and Filed Emergency and published under Notice of Intended Action:

- Removed family planning clinics from the list of providers whose rates are reduced by 5 percent (previously adopted as paragraph 79.16(1)"j") to redress the omission of the previously authorized rate increase. (See rules Adopted and Filed Emergency and published on this date as **ARC 86xxB** for more information.)
- Amended paragraph 79.16(2)"b" to restore the possibility of payment to home health agencies at 100 percent of allowable Medicaid cost instead of the previously adopted figure of 95 percent of allowable costs. Also, the phrase "less 5 percent" is removed from paragraph 79.16(2)"a," relating to the maximum Medicare rate.
- Amended subrule 79.16(4) to provide that the 5 percent reduction for remedial services is applied to the established rate maximum instead of to the actual and allowable cost of the provider's operation.

- Amended subrule 79.16(6) to clarify that the 5 percent reduction for psychiatric medical institutions for children is applied to the upper limit for the payment rate instead of to the facility's cost for the service.

- Added paragraphs "a" and "b" to subrule 79.16(9) to clarify how the reimbursement reduction shall be applied to targeted case management service, depending on whether the provider's actual cost is more or less than the calculated interim rate.

- Added language to paragraph 79.16(10)"b" to clarify that the adjusted actual costs for home- and community-based waiver services shall not exceed the upper limits as specified in subrule 79.1(2) less 2.5 percent.

These amendments do not provide for waivers in specified situations. Needed savings will not be realized if waivers are granted. Requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441--1.8(17A,217).

The Council on Human Services adopted these amendments on March 10, 2010.

The Department finds that these amendments confer a benefit on Medicaid providers by. easing some of the effects of the reimbursement reductions. Therefore, these amendments are filed pursuant to Iowa Code section 17A.5(2)"b"(2), and the normal effective date of these amendments is waived.

These amendments are intended to implement Executive Order 19 and Iowa Code Chapter 249A.

These amendments shall become effective on March 10, 2010, at which time the amendments Adopted and Filed Emergency are rescinded.

The following amendments are adopted.

ITEM 1. Rescind subparagraph **78.10(1)"f"(1)** and adopt the following **new** subparagraph

in lieu thereof:

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

ITEM 2. Rescind paragraphs **78.13(5)"a"** and **"b"** and adopt the following **new** paragraphs in lieu thereof:

a. When transportation is by car, the maximum payment that may be made will be the actual charge made by the provider for transportation to and from the source of medical care, but not in excess of 30 cents per mile.

b. When public transportation is utilized, the basis of payment will be the actual charge made by the provider of transportation, not to exceed $1.40 per mile.

ITEM 3. Rescind subrule **79.1(8)** and adopt the following **new** subrule in lieu thereof:

79.1(8) Drugs. The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to October 7, 2008. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.

a. Reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered non-specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph "g"; or

2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph "g."

(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph "g."

(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2 plus the professional dispensing fee specified in paragraph "g."

(4) The submitted charge, representing the provider's usual and customary charge for the drug.

b. Reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered non-specialty brand prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph "g,"; or

2. For covered specialty brand prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph "g."

(2) The submitted charge, representing the provider's usual and customary charge for the drug.

c. No payment shall be made for sales tax.

d. All hospitals that wish to administer vaccines which are available through the vaccines for children program to Medicaid members shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.

e. The basis of payment for nonprescription drugs shall be the same as specified in paragraph "a" except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.

f. An additional reimbursement amount of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

g. The professional dispensing fee is $4.57 or the pharmacy's usual and customary fee, whichever is lower, except for the period from December 1, 2009, to June 30, 2010, during which the professional dispensing fee shall be $4.34.

h. For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

i. Pharmacies and providers that are enrolled in the Iowa Medicaid program shall make available drug acquisition cost information, product availability information, and other information deemed necessary by the department to assist the department in monitoring and revising reimbursement rates subject to 79.1(8)"a"(3) and 79.1(8)"c" and for the efficient operation of the pharmacy benefit.

(1) Pharmacies and providers shall produce and submit the requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

(2) Pharmacies and providers shall submit information to the department or its designee within 30 days following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy or provider.

j. Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

ITEM 4. Rescind rule 441--79.16(249A) the following **new** rule in lieu thereof:

441—79.16(249A) Payment reductions pursuant to executive order. The following payment provisions shall apply to services rendered during the period from December 1, 2009, to June 30, 2010, notwithstanding any contrary provision in this chapter.

79.16(1) Notwithstanding any provision of subrule 79.1(2), payment for covered services rendered by the following providers shall be reduced by 5 percent from the rates in effect November 30, 2009:

a. Ambulance services.

b. Ambulatory surgical centers.

c. Advanced registered nurse practitioners, including certified nurse-midwives.

d. Audiologists and hearing aid dealers.

e. Behavioral health providers

f. Birth centers.

g. Chiropractors.

h. Clinics.

i. Durable medical equipment, medical supply, orthopedic shoe, and prosthetic device dealers.

j. Hospitals, not including services rendered by critical access hospitals or services billed under the IowaCare program, but including:

(1) Inpatient hospital care, including Medicaid-certified psychiatric and rehabilitation units.

(2) Outpatient hospital care.

(3) Indirect medical education payments.

(4) Direct medical education payments.

(5) Disproportionate-share payments (except for payments to the Iowa state-owned teaching hospital).

k. Independent laboratories and X-ray providers.

l. Independently practicing occupational therapists, physical therapists, and psychologists.

m. Lead inspection agencies.

n. Maternal health centers.

o. Optometrists and opticians.

p. Physicians, excluding services billed to the IowaCare program except for preventative examinations.

q. Podiatrists.

r. Rehabilitation agencies.

s. Screening centers.

79.16(2) Notwithstanding any provision of subrule 79.1(2), the basis of reimbursement for skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services, and home health care for maternity patients and children provided by home health agencies shall be retrospective cost-related with cost settlement based on the lesser of the following:

a. The maximum Medicare rate in effect November 30, 2009,

b. The maximum Medicaid rate in effect November 30, 2009, less 5 percent, or

c. 100 percent of the reasonable and allowable Medicaid cost.

79.16(3) Notwithstanding any provision of subrule 79.1(2), the basis of reimbursement for private duty nursing and personal care for persons aged 20 or under provided by home health agencies shall be retrospective cost-related with cost settlement based on the lesser of the following:

a. The maximum Medicaid rate in effect November 30, 2009, less 5 percent, or

b. 100 percent of the reasonable and allowable Medicaid cost.

79.16(4) Notwithstanding any provision of subrule 79.1(2) or 79.1(23), the basis of reimbursement for remedial services providers shall be consistent with the methodology

described in subrule 79.1(23) except that the reasonable and proper cost of operation is equal to 100 percent of the actual and allowable cost subject to the established rate maximum less 5 percent.

79.16(5) Notwithstanding any provision of subrule 79.1(2) or rule 441—81.6(249A), the patient-day-weighted medians used in rate setting for nursing facilities shall be calculated and the rates adjusted to provide a 5 percent decrease in nursing facility rates (except for state-owned facilities).

79.16(6) Notwithstanding any provision of subrule 79.1(2) or rule 441--85.25(249A), the basis of reimbursement for non-state-owned psychiatric medical institutions for children shall be consistent with the methodology described in 441--subrule 85.25(1) except that the per diem rate shall be based on the facility's cost for the service, not to exceed the upper limit as provided in 441--subrule 79.1(2) less 5 percent.

79.16(7) Notwithstanding any provision of subrule 79.1(2), payment for covered services rendered by dentists shall be reduced by 2.5 percent from the rates in effect November 30, 2009.

79.16(8) Notwithstanding any provision of subrule 79.1(2) or 79.1(25), the basis of reimbursement for community mental health centers shall be retrospective and cost-related with cost settlement limited to 97.5 percent of the provider's reasonable and allowable Medicaid cost.

79.16(9) Notwithstanding any provision of subrule 79.1(2), the basis of reimbursement for targeted case management shall be as follows:

a. A provider-specific prospective cost-based interim rate shall be calculated based on the finalized state fiscal year 2009 cost report plus an inflation factor of 2.3 percent.

b. For a provider whose actual and allowable cost is less than the prospective cost-based interim rate calculated pursuant to paragraph "a," the cost-settled amount paid to the provider shall be 100 percent of the provider's actual and allowable cost.

c. For a provider whose actual and allowable cost is greater than the prospective cost-based interim rate calculated pursuant to paragraph "a," the cost-settled amount paid to the provider shall be actual cost less 2.5 percent, not to be reduced below the prospective cost-based interim rate.

79.16(10) Notwithstanding any provision of subrule 79.1(2), payment for covered services rendered by home- and community-based waiver service providers shall be reduced by 2.5 percent from the rates in effect November 30, 2009.

a. Rates based on a submitted financial and statistical report shall be consistent with the methodology described in subparagraph 79.1(15)"d"(1) except that the inflation adjustment applied to actual, historical costs and the prior period base cost shall be reduced by 2.5 percent.

b. The retrospective adjustment of prospective rates shall be made based on revenues exceeding 100 percent of adjusted actual costs. Adjusted actual costs shall not exceed the upper limits as specified in subrule 79.1(2) less 2.5 percent.

This rule is intended to implement Executive Order 19 and Iowa Code chapter 249A.

ITEM 5. Rescind subparagraph **81.6(16)"a"(1)** and adopt the following **new** subparagraph in lieu thereof:

(1) Non-state-owned nursing facilities. Patient days for purposes of the computation of administrative, environmental, and property expenses for non-state-owned facilities shall be inpatient days as determined in subrule 81.6(7) or 90 percent of the licensed capacity of the

facility, whichever is greater. Patient days for purposes of the computation of all other expenses shall be inpatient days as determined in subrule 81.6(7).

ITEM 6. Rescind subparagraph **81.6(16)"h"(9)** and adopt the following **new** subparagraph in lieu thereof:

(9) Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual total patient days.

1. Total patient days shall be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of calculating the add-on, total patient days shall be the greater of the estimated annual total patient days or 90 percent of the facility's estimated licensed capacity.

2. The annual estimated property costs for the project are calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

3. A reconciliation between the estimated amounts and actual amounts shall be completed as described in subparagraph (12).

ITEM 7. Rescind subparagraph **81.6(16)"h"(12)** and adopt the following **new** subparagraph in lieu thereof:

(12) Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the Iowa Medicaid enterprise

shall recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual financial and statistical report. A separate reconciliation shall be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. For purposes of recalculating the capital cost per diem instant relief add-on, total patient days shall be based on the greater of the number of actual patient days during the period in which the add-on was paid or 90 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid.

2. The recalculated capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit as determined in paragraph "f." The facility's quarterly rates for the relevant period shall be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid shall be repriced to reflect the recalculated capital cost per diem instant relief add-on.

ITEM 8. Rescind paragraph **81.10(4)"f"** and adopt the following **new** paragraph in lieu thereof:

f. Payment for periods when residents are absent for a visit shall be made at 42 percent of the nursing facility's rate. Payment for periods when residents are absent for hospitalization shall:

(1) Be made at 25 percent of the nursing facility's rate if the facility occupancy percentage is 95 percent or greater.

(2) Not be made if a facility's occupancy percentage is less than 95 percent.

(3) Be made at 42 percent of the nursing facility's rate for special population facilities.